THE DRIP WELLNESS BAR, LLC

Weight Management Medical History Form

This form is confidential. Please fill out completely.

Patient Name_ _____ Date: _____

Name Prefer to be called _____

Address _____ City: _____ State_____Zip Code_____

Sex _____ Date of Birth: _____Age_____Race _____

Phone:_____Cell_____Work _____

Email: _____ Preferred Contact Method _____

May we leave a message on a home machine or voice mail? _____

Social Security Number XXX-XX-_____Occupation _____

Employer _____Language Preferred_____Ethnicity _____

Marital status: _____ Spouse's Name: _____Date of Birth _____

Emergency Contact Name _____

Phone number_____Relationship to patient _____

Who referred you to our practice? _____

Pharmacy name _____

Phone Number _____

Address_____City _____State_____ Zip Code _____

Primary Care Physician _____

Address _____City_____State _____Zip Code_____

Describe the main reason for your visit today:

_____

_____

_____

How does your weight affect your daily life?

_____

Any other symptoms associated with your chief complaint?

_____

Lowest Weight: _____ **When?**_____

Heaviest Weight _____ **When?**_____

What is your goal weight or a weight where you felt comfortable?

_____

What is motivating you to lose weight? _____

What challenges do we need to overcome to reach your goal? _____

Past Weight Loss Programs/plans: (Check all that apply)

- ☐ **Weight Watchers**
- ☐ **Jenny Craig/Nutrisystem**
- ☐ **South Beach/ Atkins/ Low Carb/ Keto**
- ☐ **Medically Supervised Treatment: (Describe)**

Social History

(please circle yes or no)

Do you smoke? YES/NO If yes, # cigarettes per day _ How long? _____ Past Smoker? Yes / N

Do you use smokeless tobacco? YES/NO If yes, how long? _____
Do you drink alcohol? YES/NO If yes, how much and how often? _____
Caffeine Use YES/NO If yes, please state amount and frequency. _____
Do you use recreational drugs such as Cocaine, Marijuana or Methamphetamine? YES/NO If yes, please list the drug name and frequency: _____
Do you exercise? Yes/ No If yes, please describe your exercise habits.

_____

Medical History

Are you allergic to any Medication? Yes/No If yes, list the medication and reaction.

_____

Do you take any medication? Yes/ No. If yes, please list (include herbal medication)

Medication	Dosage	Frequency

Have you been hospitalized or undergone a surgical procedure? Yes/ No If yes, please list:

Surgery/Illness	Date	Physician	Hospital

FEMALES ONLY:

Last Physical Exam: Physician: _____Date _____
Last Pap Smear: Physician: _____Date _____
Was your last pap smear Normal or Abnormal? _____
Last Menstrual period: _____
Do you have regular periods? _____
Have you been through menopause? _____Method of birth control _____
Have you ever been pregnant? _____ If yes, # of times _____
Are you pregnant or breast feeding?
Date of last Mammogram _____normal or abnormal? _____
Have you ever had a Bone Density Scan (DEXA) to check for osteoporosis?_____If so, when?
_____

MALES ONLY:

Last Physical exam: Physician _____ Date_____
Date of last Prostate and Rectal Exam? Physician _____ Date_____

Any Dietary/Nutrition Restriction? (Include food allergies)

MENTAL HEALTH		
Is stress a major problem for you?	**YES**	**NO**
Do you feel depressed often?	**YES**	**NO**
Do you panic when stressed?	**YES**	**NO**
Do you have problems with your appetite?	**YES**	**NO**
Do you cry often?	**YES**	**NO**
Have you ever attempted suicide?	**YES**	**NO**
Have you ever thought about injuring yourself?	**YES**	**NO**
Do you have difficulty sleeping?	**YES**	**NO**
Have you ever seen a counselor / Therapist?	**YES**	**NO**

If you have ever received in patient treatment for a mental health illness or for substance abuse please explain ?

Have you ever or are you experiencing any of the following? (Check all that apply)

Constitutional Symptoms
- □Weight gain ___lbs
- □Fever/Chills
- □Weight loss___lbs
- □Night Sweats
- □Fatigue
- □Appetite change

Eyes
- □Glaucoma
- □Vision loss
- □Blurred/Double vision

Ear/Nose/Throat/Mouth
- □Hearing loss
- □Nasal congestion
- □Snoring
- □Mouth/throat irritation
- □Tooth problems

Respiratory
- □Shortness of Breath
- □Cough
- □Wheezing

Cardiovascular
- □Chest pain/Pressure
- □High/Low blood pressure
- □Heart
- □Heart Failure
- □Heart attack
- □Sweating
- □Ankle swelling
- □Syncope/Passing out

Gastrointestinal
- □Nausea/Vomiting
- □Abdominal Pain
- □Constipation
- □Diarrhea
- □Blood in Stool
- □Liver disease
- □Difficulty Swallowing
- □Heartburn

Integumentary
- □Skin Rash
- □Dry Skin
- □Eczema

Genitourinary
- □Urinary retention
- □Pain with
- □Kidney Disease
- □Incontinence
- □Urinary frequency
- □Urinary hesitancy
- □Sexual problems
- □Vaginal dryness
- □Vaginal discharge
- □Frequent UTIs

Neurological
- □
- □Stroke
- □Insomnia
- □
- □Dizzy
- □Seizures
- □Bipolar disorder

Hematologic/Lymphatic
- □Swollen glands
- □Easy bleeding or DVT treatment□Blood
- □Anemia

Musculoskeletal
- □Muscle Wasting
- □Arthritis
- □Pain
- □Stiffness
- □Weakness

Endocrine
- □Change in Sex Drive
- □Cold or Heat
- □Thyroid Problems
- □Blood Sugar
- □Change in Body Hair
- □Excessive Thirst

□I have not experienced any of the symptoms above

I/My Family has a history of: (please check all that apply & list Family Member)

	Me	Family	Comment		Me	Family	Comment
Anemia	☐	☐	_____	Hormone Disorders	☐	☐	_____
Breast Disease	☐	☐	_____	Kidney Disease	☐	☐	_____
Cancer	☐	☐	_____	Kidney Stones	☐	☐	_____
Chronic Pain	☐	☐	_____	Liver Disease	☐	☐	_____
Depression/Anxiety	☐	☐	_____	Lung Disease	☐	☐	_____
Diabetes, Type1or2	☐	☐	_____	Neurological	☐	☐	_____
Diverticulosis	☐	☐	_____	Osteoporosis	☐	☐	_____
Endometriosis	☐	☐	_____	Overactive Bladder	☐	☐	_____
Erectile	☐	☐	_____	Obesity	☐	☐	_____
Fractures	☐	☐	_____	Psychological	☐	☐	_____
Gout	☐	☐	_____	Stroke	☐	☐	_____
Glaucoma	☐	☐	_____	Stomach ulcers	☐	☐	_____
Heart Disease	☐	☐	_____	Seizures	☐	☐	_____
High Cholesterol	☐	☐	_____	GERD/Acid Reflux	☐	☐	_____
HIV/AIDS	☐	☐	_____	Sickle Cell Anemia	☐	☐	_____
Hemorrhoids	☐	☐	_____	Sleep Disorders	☐	☐	_____
Headache	☐	☐	_____	Thyroid Disease	☐	☐	_____
Hepatitis	☐	☐	_____	Spine	☐	☐	_____
Allergies	☐	☐	_____	STDs	☐	☐	_____

Other: _____

If there is anything not listed on this form that you feel the physician should be aware of please list here:

_____

_____

☐ **I, the undersigned, understand that I may choose to take medication for the purpose of appetite suppression and weight loss. I have been advised of the effects and side effects this medication may produce and further advised that if adverse effects are noticed I will stop taking medication and call The Drip Wellness Bar ASAP. Business hours are Monday thru Thursday 9-5pm and Friday 9-3pm. If an adverse reaction happens outside of business hours, I understand that I am to go to the nearest Emergency Room. I also understand that if I become pregnant, I will stop any and all medications given to me and notify the provider.**

☐ **I do not wish to take any medication for appetite suppression or weight loss.**

I (the patient) agree to submit this medical history as accurately, completely, and to the best of my recollection. I agree that failure to provide truthful, accurate and complete information on this history form to The Drip Wellness Bar, LLC to the providers of The Drip Wellness Bar, LLC could result in inappropriate treatment. I also understand that this record submitted will be held in the highest confidentiality as set by the Health Information Act as well as other established law and will only be used to further my medical treatment.

_____ _____

Print Name **Signature** **Date**

Reviewed by _____

VENIPUNCTURE/INJECTION CONSENT FORM

I understand the general risks associated with this therapy may include, but are not limited to bruising, soreness, pain, local swelling, redness, and possible infection when the skin barrier is compromised; these are potential risks with any injection.

I understand that there are risks both known and unknown to any medical procedure, treatment, or therapy and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these unknown risks.

Signature Date

Witness Date

WEIGHT LOSS CONSENT FORM

I _____ authorize The Drip Wellness Bar, LLC and any designated associate or assistants, to help me with my weight reduction efforts. I understand that the success of my weight loss depends upon my effort and there are no guarantees of weight loss or how long I will maintain any weight lost during the weight management program. Obesity may be a chronic condition that requires permanent changes in behavior including dietary and exercise habits to be treated successfully.

My weight loss program may include a reduced calorie diet, exercise program, appetite suppressant medications and instruction in behavior modification. I understand that any weight loss regimen may involve risks as well as benefits. I also understand that there are significant health risks associated with being overweight or obese. Risks of the weight loss program may include but are not limited to fatigue, headaches, trouble sleeping, dry mouth, diarrhea, constipation, anxiety, depression, elevated blood pressure, heart irregularities/arrhythmias and very rarely death. Risks associated with remaining overweight or obese may include elevated blood pressure, diabetes, heart disease, heart attacks, arthritis, cancer, sleep apnea and sudden death.

My weight loss program may include FDA approved appetite suppressant medications. These medications may be given for longer periods of time than recommended by appetite suppressant labeling. I understand that this is considered "off label" and have been informed of risks involved, including risk of heart disease.

My weight loss program may include natural formulations and vitamin products which have not been evaluated by the FDA. In keeping with government regulations, we make no therapeutic or medical claims on these products. I have read and fully understand this consent form. I realize that I should not sign the consent form if all items have not been explained to me. My questions have been answered to my complete satisfaction.

Date: _____ Patient: _____

Witness: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to The Drip Wellness Bar, LLC, its affiliates, and its employees. The Drip Wellness Bar, LLC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by The Drip Wellness Bar, LLC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address shown at the bottom of this notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may use your information to prepare a bill to send to you or to the person responsible for payment regarding your procedures or treatment.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations. such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law.
- Public health activities such as required reporting of immunizations, disease, injury, birth, and death, or in connection with public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- To your employer when we have provided health care to you at the request of your employer.
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings.
- Court or administrative ordered subpoena or discovery request.
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To coroners and/or funeral directors consistent with law.
- If necessary, to arrange an organ or tissue donation from you or a transplant for you.
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value. Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities.
- Research purposes if we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes.

- Treatment and payment purposes.
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence.
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures.
- Disclosures required by law.
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" by calling the Privacy Officer at (706) 221-4848. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" by calling the Privacy Officer at (706) 221-4848.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your
behalf, has paid [Practice Name] in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address shown at the bottom of this notice.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer at The Drip Wellness Bar, LLC. To file a complaint with The Drip Wellness Bar, LLC Please contact 561-309-9739.

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

We at The Drip Wellness Bar, LLC are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____ Relationship to patient

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Notice of Privacy Practice Given- Patient is unable to sign

_____Notice of Privacy Practice Given-Patient refused to sign